

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1938 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 09/22/2021 |
| NAME OF PROVIDER OR SUPPLIER NASHVILLE CENTER FOR REHABILITATION A | | STREET ADDRESS, CITY, STATE, ZIP CODE 832 WEDGEWOOD AVENUE NASHVILLE, TN 37203 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| N 002 | 1200-8-6 No Deficiencies This Rule is not met as evidenced by: An investigation of Complaints #TN00055294 was conducted on 9/22/2021 at Nashville Center for Rehabilitation and Healing. There were no deficiencies cited in relation to complaint #TN00055294 under Chapter 1200-8-6, Standards for Nursing Homes. | N 002 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE